Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX Health DBA Injury 1 of Dallas

Respondent Name
Accident Fund National Insurance

MFDR Tracking Number
M4-13-0013-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
September 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…it is our position that Accident Fund has established an unfair and unreasonable time frame in paying for the services that were medically necessary..."

Amount in Dispute: $1,148.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Carrier respectfully requests that this dispute be dismissed pending resolution of the extent of injury dispute. ""

Response Submitted by: Stone Louglin & Swanson LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2012	90801	$1,148.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 201 – Service outside approved utilization control
   - 39 – Services denied at the time authorization/re-certification was requested
   - 18 – Duplicate claim/service
   - 247 – A payment or denial has already been recommended for this service

Issues

1. Did the respondent raise a new issue when responding to MFDR request?

2. Did the requestor support the disputed services are not subject to prior authorization?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.307(d)(2)(F) states in pertinent part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…" Therefore the disputed services will be reviewed per denial reasons provided at the time the claim was initially adjudicated and reconsidered.
2. The carrier denied the disputed services as, 39 – "Services denied at the time authorization/re-certification was requested." 28 Texas Administrative Code §134.600(p)(7) states in pertinent part, "Non-emergency health care requiring preauthorization includes:… all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program…" Review of the submitted documentation found nothing to support the disputed service was part of a preauthorized or division exempted return-to-work rehabilitation program. The carrier's denial is supported.
3. Requirements of 134.600 were not met. No recommendation for payment can be made.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 10, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.